

CMC Imaging Services Limited

Heath Lodge

Inspection report

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Date of inspection visit: 10 May 2023
Date of publication: 10/07/2023

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location

Good



Are services safe?

Good



Are services effective?

Inspected but not rated



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

Overall summary

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced visit to Heath Lodge Clinic on 10 May 2023.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

This is the first time we rated this service. We rated this service as good because it was safe, caring, responsive and well led. We inspect but do not rate effective in diagnostic imaging services.

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff assessed risks to patients, acted on them and kept good care records as minimised infection risks. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment using best evidence based practice. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of the communities it served, took account of patients' individual needs, and made it easy for people to give feedback. People accessed the service when they needed it and did not have to wait too long for a diagnostic procedures and reports.
- Leaders ran services well using reliable information and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- The service did not have formalised records for all their governance meetings. Some were not always recorded, comprehensive and/or standardised.
- Records of cleaning for ultrasound probes were not always fully completed.
- Local rules were signed by staff however, this was only done once and not when new local rules were produced or after every change.

Summary of findings

Our judgements about each of the main services

Service

Diagnostic imaging

Rating

Good



Summary of each main service

This is the first time we are rating this service. We rated this service as good because it was rated good for safe, caring, responsive and well-led. We do not currently rate effective in diagnostic imaging services. See the summary above for details.

Summary of findings

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Summary of this inspection

Background to Heath Lodge

Heath Lodge is part of CMC Imaging Services Limited. The service offered the following services: x-ray, dual energy x-ray absorptiometry (DEXA) scanning magnetic resonance imaging (MRI) 3T and 1.5T, and ultrasound for guided injections and diagnostic procedures. The service provided care to adults and children who were aged 8 and above.

The service provided diagnostic imaging services mainly to self-funding patients. There were no NHS contracts but the service had a referral pathway for NHS patients who suffered from claustrophobia and bariatric patients who could not undergo diagnostic imaging at their local hospital.

This is the first time we will rate the inspected service.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced inspection on 10 May 2023.

During the inspection we spoke with 10 members of staff, including the service managers, radiographers, and registered manager as well as administrative staff and 5 patients. We reviewed 5 sets of patient records and a range of policies, procedures and observed patient care.

The inspection team comprised of a lead CQC inspector and a CQC specialist advisor. The inspection team was overseen by an operations manager and deputy director.

You can find information about how we carry out our inspections on our website: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>.

Areas for improvement

Action the location **MUST** take is necessary to comply with its legal obligations. Action a location **SHOULD** take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service **SHOULD** take to improve:

- The service should ensure the successful implementation of their governance and communication strategy within the stipulated delivery timeline. (Regulation 17)
- The service should consider the use of a standardised recording form for all team meetings.
- The service should fully complete all documented cleaning records for the ultrasound probes.
- The service should have local rules signed by staff when new local rules were produced or after every change.
- The service should consider using review by and editing date markers on the local rules to ensure staff are using the most up to date version of the document.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Good	Inspected but not rated	Good	Good	Good	Good
Overall	Good	Inspected but not rated	Good	Good	Good	Good

Diagnostic imaging

Safe	Good 
Effective	Inspected but not rated 
Caring	Good 
Responsive	Good 
Well-led	Good 

Is the service safe?

Good 

This is the first time we rated safe at this service. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training. We reviewed evidence of mandatory training records provided by the provider. The average of all mandatory training for diagnostic imaging staff groups had a 94% compliance rate.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training modules provided to staff included: intermediate life support training for all clinical diagnostic imaging staff groups, Equality and Diversity, Fire Safety, and manual handling. Mandatory training was a combination of online and face to face training ensuring the training was appropriate for the subject being delivered.

Managers monitored mandatory training completion through supervision and the online training system. They alerted staff when they needed to update their training. Staff stated they were informed by managers when they needed to undertake or update their mandatory training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. All staff had received safeguarding level 2 training for adults and safeguarding level 2 training for children. The service had a safeguarding policy which reflected the best practice and all required national guidance.

The service had a safeguard lead who was trained to level 2 for both adults and children. They had training planned and in place to do level 3 training. The safeguard lead was supported by another member of staff who was trained to level 3 in children and adult safeguarding, as well as by the local authority which provided information and support for any relevant safeguard queries.

Diagnostic imaging

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff gave examples of when they would need to raise a safeguarding concern and what specific issues they may need to look out for, such as child abuse, domestic violence, and female genital mutilation (FGM). The service had a section within its safeguarding policies relating to FGM, and what procedures to undertake if this was identified. Staff we spoke with were able to tell us how to make a safeguarding referral and who to inform if they had concerns.

The provider had a chaperone policy, which staff were knowledgeable about and could access easily.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff followed safe procedures for children visiting the diagnostic imaging service. Children were accompanied by a parent or carer and the parent or carer were able to wait with the child for their scan. Parents and carers were also able to accompany their child into the scan room and left when radiation was present.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinical areas were visibly clean and had suitable furnishings which were clean and well-maintained. The communal patient and staff areas as well as clinical rooms in diagnostic imaging areas we visited were visibly clean. Patient changing areas were clean and free of dust. There were clean gowns for patients to use when changing.

The service performed well in audits for cleanliness. We reviewed audits undertaken between January 2023 and March 2023, and found the service consistently met their compliance targets. The audit included standards for environmental cleanliness, decontamination, waste management, and staff practice. Where the audit identified standards were not met, the audit tool included an evidence area and an action plan to be completed to improve practice.

Radiographers were responsible for the cleaning of the diagnostic equipment. Staff cleaned equipment after patient contact. IPC audits included assurance sections on equipment decontamination, and staff ensured that clinical equipment was appropriately cleaned between uses.

We were informed and policies were in place to ensure ultrasound probes were cleaned in line with best practice, however, the cleaning process was not fully documented and audited as the serial number of the probes were not recorded.

The service took steps to minimise cross infections. Each clinical area had foot operated clinical waste bins. Sharps bins present were visibly clean, not over filled, and secure.

Cleaning records for the environment were up-to-date and demonstrated that all areas were cleaned regularly. We reviewed cleaning logs on site which showed that cleaning was completed with daily and weekly checklists. Cleaning was assigned to an external company. The service ensured all staff that were cleaning the facilities had an induction in safety and care when near or entering controlled areas.

Staff followed infection control principles including the use of personal protective equipment (PPE). All clinical staff we saw on inspection were bare below the elbows and washed or sanitised their hands between patient contacts. Hand sanitiser was available for staff and patients throughout the diagnostic imaging service.

Diagnostic imaging

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The environment design and layout of the various diagnostic imaging rooms followed national guidance. The layout of communal and clinical areas was in line with NHS England Health building notes guidance. Diagnostic imaging rooms had appropriate space for examination and scanning, and reception and communal areas were appropriate for patients and other visitors waiting for appointments.

Staff carried out daily safety checks of specialist equipment. The service had equipment maintenance logs to monitor when diagnostic imaging equipment was last maintained and calibrated. On inspection we observed that imaging equipment was within its period of maintenance date. In MRI there were contingency plans if equipment was faulty or not operational.

The service had enough suitable equipment to help them to safely care for patients which was serviced and maintained in line with manufacturer's requirements. We saw resuscitation equipment had been daily safety checked and was subject to monitoring.

Each modality had separate clinical rooms where the different diagnostic tests would be taken. Each room contained different diagnostic equipment, for example MRI scanner, ultrasound and X-ray. These rooms were well organised. The clinical rooms allowed private conversations to take place.

The service ensured equipment met their required needs. The service had an equipment replacement programme to monitor older equipment and was planning the installation of new equipment to be completed within the next year.

Clinical areas that had medical equipment had measures in place for their safe use, in line with legal requirements and best practice for equipment safety. There was clear signage showing where equipment may be a risk to patients, and when that equipment was in use. This also applied to information limiting access or warning of safe access to diagnostic rooms.

Lead aprons were available for use when required, these aprons were used to protect staff against radiation exposure. The aprons were well maintained and in good condition. We saw evidence that the aprons were scanned annually to check that they were undamaged and still offered full protection.

Staff disposed of clinical waste safely. Clinical waste bins had signage that indicated what was to be disposed of in them and staff we spoke with understood the process. Waste removal was subcontracted to an external company that produced removal and disposal records and an annual compliance record to support the safe management of waste.

The diagnostic imaging service regularly accessed personal dosimetry scores to ensure that employees were not exceeding annual dose limits of ionising radiation. All staff working with ionising radiation were issued with dosimeters to ensure compliance with Ionising Radiation Regulations 2017.

MRI equipment was labelled in line with the Medicines and Healthcare products Regulatory Agency (MHRA) safety guidelines for MRI equipment in clinical use. This included clearly displaying information where items and equipment were safe or unsafe for use with MRI equipment.

Diagnostic imaging

The MRI areas displayed information showing the limit of the "5 Gauss line" and it was clear from the evidence provided how the risk to patients and staff was being mitigated. The 5 Gauss line shows the area around an MRI machine at which the magnetic fields are more than five Gauss, a measure for the strength of a magnetic field. This is an important safety consideration as when the magnetic field is equivalent to or over five Gauss, it can present risks to patients and staff, as it affects devices such as pacemakers and implantable cardioverter defibrillators.

Clinical areas where ionising radiation was being used had controlled access and relevant safety signs in line with Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017 and national guidance.

Local rules for radiation were displayed in the scanning areas and had been signed by all appropriate members of staff. However, staff only signed this once and not every year or when local rules had changed. We were assured staff knew of changes as these were highlighted in staff meetings.

The service had suitable facilities to meet the needs of patients' families. Waiting areas in the diagnostic imaging service had suitable seating for visitors and refreshments were available in each waiting area.

The service undertook emergency evacuation simulations for MRI and the pain management unit. We reviewed the emergency pathways and practice records for simulations undertaken in June 2022 and May 2023 and found them to be comprehensive with plans which included action owner, status and completion dates.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

Staff knew how to respond promptly to any sudden deterioration in a patient's health. If a patient became unwell in the diagnostic imaging areas, there was a clear protocol to follow and emergency phone numbers to contact were visible in communal areas. Staff we spoke with were clear on how they would escalate an emergency if a patient was deteriorating and stated that the response from the medical staff would be prompt and 999 called immediately.

On inspection we saw evidence of emergency evacuation procedures for the diagnostic imaging service. We also saw consistent evidence of visible emergency evacuation information for patients in communal waiting areas.

Staff completed risk assessments for each patient and reviewed the suitability of the process regularly. Patients completed a screening process with staff to identify any potential risks that may impact the delivery of care or present potential harm to patients. As an example, female patients were asked if they were pregnant before undergoing any X-Rays.

Staff knew about and dealt with any specific risk issues. Staff used 'pause and check' and we saw posters supporting this in imaging areas. Pause and check is a checklist followed by radiographers for good practice in line with Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). When staff administered intravenous contrast, staff completed an individual patient risk assessment to identify risk of anaphylaxis. The service used the Society of Radiographers "Six Point Paused and Checked" patient identification check prior to radiological investigations. This allowed staff to ensure patient information was accurate, that any patient risk factors that had been identified could be acknowledged, and that exposure was safe for the patient.

Diagnostic imaging

Staff in the MRI area ensured all staff and patients undertook a metal screening assessment before entering the MRI room. MRI scans use strong magnets to produce images, these can affect any metal implants or fragments in the body. *Metal objects* may also interfere with the magnetic field and can cause a safety hazard.

Staff were clear on who the allocated radiation protection supervisor (RPS) for the service was. This was consistent across staff groups we spoke with, and information on who the RPS was for each area was readily available.

Staff shared key information to keep patients safe when handing over their care following conscious sedation or use of contrast. When patients were scanned, staff provided details of procedures and any contrast medicines.

The service had clear processes to action emergency findings. When imaging was completed, scans were processed and loaded into the *picture archiving and communication system* to be viewed by consultants or radiologists. If any emergency findings were detected these were escalated immediately and patient, referrer and GP notified immediately.

Staffing

The service had enough radiographers and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service had enough radiographers, sonographers and support staff to keep patients safe. Staffing levels were planned and reflected the demand on the service and known treatment support needs. Rotas were completed in advance to align with the planned activities.

Staff were separated into teams across the clinical modalities: plain film (X-ray), magnetic resonance imaging (MRI) and ultrasound.

The number of radiography staff and imaging support staff on the whole matched the planned numbers. Staff stated across modalities that the services were capable of matching staff numbers to rotas

The service had low and reducing vacancy rates. At the time of inspection, the service had identified 5 vacancies with 3 of them under offer. The service had low turnover rates. The service had a low level of sickness rates of 6.2% for 2023.

There was one permanent radiologist supporting the service who was employed directly with the provider. Other medical staff were identified as supporting medical staff including pain management consultants, reporting consultants and anaesthetists. A medical advisory committee monitored and managed medical staffing arrangements and reporting was contracted externally with the assigned reporting consultants.

Records

Staff kept detailed records of patients' care and diagnostic procedures. Records were clear, up to date, stored securely and easily available to all staff providing care. Staff always had access to up-to-date, accurate and comprehensive information on patients' care and procedures.

Patient imaging records were comprehensive, and all staff could access them easily. The service used a *picture archiving and communication system* (PACS) to store and process images.

Radiologists reported on images on electronic systems in and outside the service using protected and encrypted systems and results were securely sent to the referring clinicians.

Diagnostic imaging

We reviewed 5 sets of patient records and found they were fully completed, and all staff could access them easily. Patient notes were a mix of paper and electronic records. On inspection we observed staff storing records securely in each clinical area.

Access to computers and electronic patient records systems were password protected.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely administering, recording and storing medicines. When contrast was administered this was done under a Patient Group Direction (PGD). PGDs are written instructions to supply or administer medicines to patients, usually in planned circumstances.

Staff stored and managed medicines securely in line with the provider's policy. Staff labelled contrast with the date it entered the warming cabinet, this was monitored and disposed of after 28 days, this was in line with manufacturer's guidance. The PGDs were in date and had been reviewed by an appropriate staff group, there were also signed sheets demonstrating staff had read the PGD.

The service stored controlled drugs. Staff followed current national guidance to check patients had the correct medicines. Controlled drugs books and checks were well managed and accurate.

In the event of an emergency, both emergency resuscitation trolleys in the service had an adult anaphylaxis box which was in date and secured with a number tag for safe use.

Incidents

Staff recognised and reported incidents and near misses. When things went wrong, staff apologised and gave patients honest information and suitable support. The service managed patient safety incidents. Managers investigated incidents but the method used to share information with clinical staff did not support it being done in a timely manner.

Staff knew what incidents to report and how to report them. Training on reporting incidents was given to all staff and they were familiar with how to do this.

Managers supported staff in reporting incidents to ensure consistency. Staff raised concerns and reported incidents and near misses in line with the service's policy. Managers discussed incidents with staff at the time of reporting so that all incidents and near misses were reported. Staff knew how to report serious incidents clearly and in line with policy.

Staff we spoke with stated they had an opportunity to discuss feedback from incident investigations and that actions were taken to make improvements to patient care. Managers investigated incidents, debriefed and supported staff after any serious incident. There was evidence that changes had been made as a result of feedback.

Between May 2022 and May 2023 the service reported 58 incidents. Of these, 52 had a reported degree of harm equal to or lower than low harm. There were 5 incidents of moderate harm and 1 reported as severe harm. The incident reported as severe harm was reported and investigated appropriately and had been notified to the correct reporting agencies including CQC.

Between May 2022 and May 2023, the diagnostic imaging service reported no never events.

Diagnostic imaging

There were systems in place for radiation related incidents to be escalated to and investigated by a medical physics expert.

Staff we spoke with understood duty of candor. They were open and transparent and gave patients and families a full explanation if or when things went wrong.

Is the service effective?

Inspected but not rated 

We do not currently rate effective in diagnostic imaging services.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed policies to deliver high quality care according to best practice and national guidance. The service had policies in place to support good practice and these were available electronically. Changes in national guidance were communicated by the leaders in the service to be implemented at a service level. Guidance from the Royal College of Radiologists, the College of Radiographers and the National Institute of Health and Care Excellence were available to staff.

The service provided care and treatment based on national guidance including the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). Policies were aligned with and referenced the Ionising Radiation Regulations 2017. The Ionising Radiation Regulations 2017 are regulations concerned with the protection against exposure to ionising radiation as a result of work activities. The radiation safety policy and local rules for radiation safety were up to date and were available to staff electronically and in a hard copy folder in the treatment rooms. However, this document was not dated and did not have a clear review by date making it difficult for staff to know if this was the most updated version of the document.

Diagnostic reference levels (DRLs) were calculated on an annual basis by the radiation protection supervisor. They could be accessed on a monthly basis to review any significant variances.

We observed that all local rules were signed and dated by staff as being understood. Local rules were in each diagnostic imaging room. Managers checked that staff followed these and were updated with any changes to the rules.

The service managers shared information with their teams via staff meetings and shared learning presentations. This allowed any updates to practice and introduction of new evidence based procedures was clearly communicated and understood by staff.

Pain relief

Staff monitored patients regularly to see if they were in pain.

All patients attended as an outpatient. Staff assessed patients' pain both before and during imaging procedures. Patients attending from home were advised to bring any medication including pain relief with them, that they might require during their attendance. The service did not administer pain relief.

Diagnostic imaging

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Outcomes for patients were positive, consistent and met expectations, such as national standards. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.

Managers used information from the audits to improve care and treatment. Discussions were had between staff about recent cases and learning was used to improve the quality of care provided. Managers shared and made sure staff understood information from the audits.

The service did an MRI radiographer audit which reviewed the quality of the scans against the protocol and suitability of the scan. Between January 2022 and November 2022 the service scored 97.8% in the quality of scans against the protocol and 100% in acceptability of the scans.

Peer reviews of images had a rejection target of less than 10%. Results could be broken down to individual radiographers or specialties to identify issues. We reviewed rejection results in 2 recent audits and found rejection rates between 6 October 2021 and 4 October 2022 had a rejection of 4.4% and between 28 December 2022 to 17 May 2023 a rejection of 3.8%.

At the time of the inspection the service did not have any United Kingdom Accreditation Services (UKAS) or International Organization for Standardization (ISO) accreditations.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff were knowledgeable and able to tell us about their roles.

Managers gave all new staff a full induction tailored to their role before they started work. New staff had a local induction to the service. Staff were provided with a competency-based pack to complete. New staff were required to complete mandatory training within 3 months of starting their role, which was monitored by managers within the service.

Managers supported staff to develop through yearly, constructive appraisals of their work. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

The service was looking to establish a more robust appraisal process in the next year. Training for both managers and employees on how to carry out a One to One meeting (121) took place in November 2022 to ensure managers had the skill set to execute 121s, employees understood their active role in the process and that the clinic had a consistent approach across departments. During the second half of 2023 a half yearly and end of year a consistently recorded performance management and development system was going to be introduced to improve the quality of the appraisals delivered..

Diagnostic imaging

Managers made sure staff received any specialist training for their role. Staff we spoke with told us that they had access to training for their learning and educational needs.

Managers made sure staff attended team meetings or had access to notes when they could not attend. Meeting notes were shared with staff. However, each diagnostic modality had a different agenda and recorded their team meeting minutes in a different format which meant that cross organisational information could be missed or not considered at the time of the team meetings.

Staff who were designated as radiation protection supervisor were given the opportunity to undertake training specific to their role.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff were positive about the working relationships between staff disciplines and different modalities. Staff stated they felt well supported by managers and by colleagues.

We observed staff working well together as a team, the service had a positive and respectful atmosphere. Staff told us they believed there was very good lines of communication within the service.

The service had good relationships with external partners. We saw good communication between the services and there were opportunities for staff to contact referrers for advice and support.

The service communicated well to benefit patients' experiences. We heard how, the administration team and service leaders could contact each other to arrange and fast track any appointments.

Seven-day services

Key services were available to support timely patient care.

The service was open Monday to Friday, 8am to 6pm, and some Saturdays 9am to 5pm.

Staff could call for support from consultants and other disciplines during working hours.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff we spoke with demonstrated sufficient understanding of their responsibilities in regard to consent. Staff made sure patients consented to treatment based on all the information available.

Diagnostic imaging

Staff clearly recorded consent in the patients' records. We saw evidence that consent had been recorded in line with legislation.

Staff could describe and knew how to access policies on Mental Capacity Act.

Is the service caring?

Good 

This is the first time we rated caring at this service. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and their families in a respectful and considerate way. Staff spoke with kindness and engaged with patients to make them feel they were being listened to. Patients had the time needed to allow them to ask questions and for staff to provide explanations, preparing them for their procedures.

We spoke with 5 patients, who stated staff were very kind, friendly and considerate throughout their treatment. Staff asked patients how they felt about the imaging procedure they were having and if they had any questions.

Staff clearly explained the diagnostic procedure and the time it would take to the patient. We witnessed staff interacting with patients before and throughout their procedure. Staff gave patients positive feedback during the imaging procedure where appropriate, and continued to ask how the patient was doing. Patients were reminded to tell staff if they wanted the procedure to stop at any time.

We saw that reception staff asked patients how their procedure had gone when they left their scan. Reception staff were kind, sensitive and caring when speaking to patients on the telephone.

Staff maintained privacy and dignity by ensuring blinds and doors were closed when patients entered the room. Chaperones were available to support patients during procedures if needed.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff supported patients who became distressed and helped them maintain their privacy and dignity. There were quiet spaces within all the diagnostic imaging service sites where patients could wait prior to their scan for those patients that had to wait for this scan.

They service supported claustrophobic patients well which led to low numbers of incomplete scan. Staff told us there had been occasions when they had successfully scanned anxious patients who could not complete their scans at other services, by providing continuous emotional support and reassurance throughout their appointment.

Diagnostic imaging

Staff told us that if a patient became anxious or distressed during a scan, they would stop the scan, go into the room to reassure them and ensure they were okay to continue. When they felt the patient was too anxious and it was unsafe to continue, they would stop the scan and offer emotional support to the patient. Incomplete scans were referred back to the referrer and the service would rearrange another appointment on a date and time suitable to the patient without making them feel guilty for stopping the scan.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Patients were given clear details of when results would be known and who to contact, we were told this reduced anxiety while waiting for results.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their diagnostic procedures.

Staff made sure patients understood the diagnostic imaging procedure they were having done. Patients were provided with details of the diagnostic procedure by the referring clinician. Fee information for patients who paid for their care was available and could also be requested through the service's website.

Staff communicated with patients, relatives and carers in a way they understood, and they were invited to participate in the patients care and treatment. Staff encouraged them to ask questions, raise objections or discuss any concerns they had. Staff took time to address all concerns such as explaining what the scan was for and ensured the patient understood their condition, care, treatment and supported them on how to find further information.

Patients were able to communicate with staff throughout their scan. Patients were given a buzzer during their scan which they could use when they felt uncomfortable or when they wanted to stop the scan. Staff kept patients informed of what was being done during the scan and kept them informed of the time remaining till the scan was completed.

Relatives and carers were allowed remain with the patient for the duration of their appointment when required. If a relative or carer had a concern during the scan, staff took this seriously and ensured their concerns were addressed without delay.

Patients we spoke with told us that staff had been very reassuring and they were very satisfied with the service provided. They told us that all relevant details relating to their scan had been explained to them very well.

The service collected feedback and patient satisfaction levels with the service provided. The service requested feedback via comment cards and feedback forms. These looked at areas of client satisfaction from the booking team to the clinical staff and assessed points such as courtesy and professionalism, courtesy, presentation, and knowledge and information provided. The service collected this data and analysed it on a monthly basis and scored consistently high values of satisfaction and feedback. We reviewed the most recent feedback summary form for April 2023 and found that the overall satisfaction and impression of the service was close to 100% for the excellent rating.

Is the service responsive?

This is the first time we rated responsive at this service. We rated it as good.

Diagnostic imaging

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of the community it served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the patients it served. The service provided diagnostic imaging services to private patients who were self-referred or referred from consultants, health care professionals and other healthcare modalities.

Facilities and premises were appropriate for the services being delivered. There were waiting areas in all diagnostic imaging service sites, with hot and cold beverages available. The waiting areas were accessible to wheelchair users either by lift or were on the ground floor.

Patients were provided with information in accessible formats before appointments. Appointment letters contained information required by the patient such as contact details and directions. The letter also informed patients about their diagnostic screening procedure, including any preparation and contraindications. The appointment letter asked patients to call in if they had any queries.

We were told that the referral process facilitated the service's preparations should the patient have any communication or disability needs, and helped identify best ways to support the patients' needs.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The service had information leaflets available in languages spoken by the patients accessing the service.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff were aware of how to obtain interpreters and told us they had used them. When patients were referred, staff were given details of the preferred language spoken if this was not English for interpreters to be arranged.

Staff listened to patient's individual needs and made them comfortable during the MRI scan. Patients were given an emergency call buzzer to allow them to communicate with staff should they wish. Microphones were built into the scanner to enable two-way conversation between the radiographer and the patient.

The service was accessible to patients with claustrophobia or bariatric patients. The service had experience of managing patients who had anxiety to undergo specific diagnostic procedures and staff cared for them well.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to test and from test to results were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received diagnostic imaging within agreed timeframes.

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Managers monitored and took action to minimise missed and cancelled appointments. Patients were asked about times to avoid by staff booking their procedure, to ensure they would be able to attend. Cancellation or non-attendance were flagged to managers and referring clinicians to establish the cause. Managers ensured that patients who did not attend appointments or had their diagnostic procedure cancelled were contacted as soon as possible and rebooked at a fast and convenient time. When patients had their appointments cancelled at the last minute due to equipment failure, managers made sure they were rearranged as soon as possible and booked within national targets and guidance. Routine servicing of equipment was always planned in advance to avoid disruption.

Waiting times for appointments were monitored by the administration team who informed the clinical manager if any concerns were raised. We saw evidence that showed that between May 2022 and April 2023, most patients waited on average 3 to 5 working days to have their scan from the time of referral. Staff accommodated same-day slots whenever possible or if clinically identified as being high risk.

During our inspection we saw appointments ran to time. Clinical staff would advise patients of any delays as they signed in to the service's reception. Staff would keep patients informed of any ongoing delays.

Timely reporting was monitored and facilitated with information technology systems allowing results to pass quickly to referrers. Urgent or unexpected findings triggered an immediate process, ensuring results were seen promptly by consultants.

The service ensured reports from diagnostic screening procedures were produced in a timely way. We saw between May 2022 and April 2023 the vast majority of reports were issued to the referring clinician within 8 working days. Urgent reports however were issued on average within 1 day of the diagnostic screening procedure.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. When patient feedback indicated a negative experience, this was followed up by senior leaders with patients.

Staff understood the complaints' policy and were able to talk us through how they would handle any complaints they received. Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint had concluded.

Between May 2022 and February 2023, the service received 11 raised concerns of which 2 were managed as formal complaints. The service had a complaints policy that supported the consistent and fair management of any complaints raised.

The service had recently applied for registration with the Independent Healthcare Sector Complaints Adjudication Service (ISCAS). The application was approved during the time of inspection. This meant the service could escalate complaints to ISCAS if a patient was dissatisfied with the service's response to a complaint. The service was committed to the ISCAS code of complaint's management.

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Managers shared feedback from complaints and concerns with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice. Feedback from complaints across the service was shared with all staff and learning and improvements took place in all areas, including the diagnostic imaging service.

Is the service well-led?

Good 

This is the first time we rated well led at this service. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The clinical director and relationship manager was knowledgeable in leading the service. They had a healthcare clinical background which enabled them to understand the clinical aspects of the service, as well as being familiar with diagnostic imaging policies, procedures, and governance. They understood the challenges to quality and sustainability that the service faced, and together with the service leads, had proactive ongoing action plans in place to address them.

The service had an established leadership structure. The clinical director, an experienced radiologist, oversaw the day to day running of the service. The service then delegated responsibilities in each diagnostic speciality to an MRI lead, ionising radiations lead, practitioner lead and quality and compliance managers.

There was an identification of who was responsible for the service in the absence of the clinical director and how the service continued to operate in this case. Additionally, we were informed of plans to renew and strengthen the leadership team with the introduction of a clinical services manager.

The clinical director was aware of the scope and limitations of the service, based on the size, numbers and type of staff, and type of work booked. All staff told us leaders were keen to develop the service to ensure patients received a quality service.

Staff said they felt leaders engaged with and listened to them. Leaders supported staff in their development and encouraged them to own their achievements in their diagnostic imaging specialities.

Leaders and managers had an open-door policy and supported staff to raise concerns and seek out support. Staff said they felt able to approach management and discuss any concerns with them.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a clear vision for what it wanted to achieve and a strategy to turn it into action. The vision was supported by the service's values.

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The clinical director identified three main key areas in the service's strategy to ensure growth and sustainability of this service and to continue the provision of safe effective care for patients. These were based on the need to maintain a high standard of care and quality of the images produced, maintain their local profile and preference for referrals with key stakeholders and maintain a motivated workforce.

The service operated a collaborative approach to diagnostic imaging, working with clinicians, local health providers and independent providers to keep the patient at the heart of their service. The collaborative approach to imaging services was designed to future proof the service and support local pathways of care.

We saw how the service invested in their teams, infrastructure and approach to quality, to ensure they could continue to deliver on their key quality goals. This included plans to update their governance structure and acquire new diagnostic imaging equipment.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Diagnostic imaging staff we spoke with stated they felt valued and supported. Patients we spoke with were positive about the service they received from the service and staff were quickly available to answer any questions or address any issues they raised.

Staff consistently told us they were happy to work for the service and enjoyed their work despite the busy environment. They felt that they worked well together as a team to provide good patient-centred care.

Staff worked in collaborative and cooperative teams with the administration team connecting all the diagnostic specialities. The service had a culture which was centred on the needs and experience of the patients who use the services and had robust mechanisms to gain patient feedback and improve services as a result.

The culture encouraged staff to be open and honest with their service leads. We saw this also carried over to people who used services and in response to incidents and complaints. Staff were supported to raise concerns and stated that they felt they would be listened to.

The service had mechanisms for providing staff with opportunities for career development. However, because of feedback and an aim for further improvement the service had committed to overhauling their appraisal and development system and introducing new forms and training for the provision of 1 to 1s, including performance review and training opportunities. Staff were in the process of receiving training to appropriately conduct these reviews and implementation was due in the next months following our inspection.

Governance

Leaders used governance processes, throughout the service to monitor performance and outcomes. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, records of these meetings were not always recorded, comprehensive and/or standardised.

The service had governance processes, throughout the service to monitor performance and outcomes. These included the use of performance and outcome audits, patient satisfaction questionnaires and other auditing processes. These

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were reviewed in bi-annual clinic briefing meetings. However, when we requested the minutes and actions of these meetings they were not available. We were informed that the clinical briefing meetings were held as an overview of the staff monthly meetings and if any actions were required the clinical director was responsible to highlight these to the diagnostic specialities and these were reviewed and actioned in the monthly meetings.

Each diagnostic speciality held monthly team meetings with staff to communicate, monitor and introduce new policies and procedures. We reviewed the meeting minutes of the radiographers monthly meetings, and pain management unit meeting minutes. However, each diagnostic modality had a different agenda and recorded their team meeting minutes in a different format which meant that cross organisational information could be missed or not considered at the time of the team meetings.

The service had a radiation protection committee meeting which supported the safe management of the radiation protection advisor audit programme as well as reviewing radiation protection policies, local rules and relevant risk assessments.

The service had a Medical Advisory Committee (MAC) which advised on matters such as scope of consultant practice, patient outcomes, clinical standards and implementing new and emerging professional guidance. We were advised the MAC has to date operated in a loose configuration proportionate to the clinical needs of the service, however, the service also recognised the requirement to formalise this committee with a draft agenda agreed. In March 2023 steps were taken to formalise the structure with a view to preparing for the appointment of the new clinic manager.

The service recognised the need to improve their governance processes and structure prior to our inspection and was in the process of implementing their governance and communication strategy. This had been an ongoing project in the past year, which had delays in implementation due to challenges in recruiting for the clinical service manager role and also due to the fact that clinical leads had been drawn into more clinical roles to support staff. We were assured that as of end of June 2023, the new executive clinic manager, and support manager would introduce the timetabling and coordinating a yearly rolling programme of clinic wide meetings. Additionally, departmental leads and the clinic director have undertaken specific workshops to equip them with the skills to support the process effectively.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

We saw local risk assessments in place that assured the monitoring of the main risks to the service. The ongoing risk management system was completed by the clinical leads with supervision from the clinical director. However, risks were not held in one location and the service did not have a standardised risk review system that recorded when risks had been completed or were for review. This was highlighted to the clinical director who assured us that as part of the governance and communication strategy for the service a risk register was being created. This risk register would contain corporate and local risks as well as ensuring the safe management of the risk assessments in place.

The registered manager and staff were aware of patient risk related matters, such as safeguarding, reporting of incidents, policies for safe practice and safe capacity. These documents were readily available for consultation.

The service had agreements with external organisations to ensure risks were identified and mitigated appropriately. For example, the service had a designated radiation protection advisor (RPA) who supported the management of risks and auditing of the RPA audit.

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The department had 1 radiation protection supervisors in place. Controlled radiation area signs gave contact names and contact details for the radiation protection supervisor. Radiation protection supervisors are appointed for the purpose of securing compliance with the Ionising Radiations Regulations 2017 for work carried out in an area which are subject to local rules.

The diagnostic imaging service had plans to cope with unexpected events, including adverse reactions during procedures and unexpected equipment failure. There was a risk management policy and the service undertook risk assessments, for example of control of substances hazardous to health (COSHH).

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats.

The diagnostic imaging service ensured data or notifications were sent to external bodies as and when required. We saw evidence that notifications such as incidents were submitted to regulators. Policies and procedures and data about performance were stored electronically.

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems. There were effective technology systems to monitor and improve the quality of care. Access to information systems was restricted to only those who needed it, and this kept patient and confidential information secure.

The service was aware of the requirements of managing a patient's personal information in accordance with relevant legislation and regulations such as the General Data Protection Regulation (GDPR) 2018. Electronic systems, such as those used to store records and manage patient appointments, required password access. Diagnostic scan results, reports and images were stored electronically and could be accessed by staff via a secure system when required.

Engagement, learning, continuous improvement and innovation

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. All staff were committed to continually improving services.

Leaders engaged with staff using a variety of methods, including team meetings, electronic communication, staff notice boards and informal discussions. Staff felt their view and opinions were listened to.

The service had a network of regular referrers with whom they communicated to understand the needs of the service and the patients. Referrers included medical referrers, radiologists, physiotherapists and other healthcare professionals.

The service regularly engaged with consultants and professionals from the local NHS trust. This ensured practices were updated and new information regarding evidence-based practice was disseminated. This included the discussions of care plans and practices.

The service engaged with patients and sought feedback to improve the quality of the services provided. Patient feedback forms provided areas of open text for qualitative information. Patient feedback was displayed and shared with the team. Staff we spoke with could give examples of changes that had been made based on patient feedback.

The service contributed with its reporting and outcomes to the publication of reports and case studies.